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Richmond, Virginia 23219
(804) 225-2136
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Commonwealth of Virginia

Department of Human Resource Management

Office of Workforce Engagement

NOTICE OF APPEAL - COMPLAINANT

1.	**Complainant Information:**					
	Name:					
	Mailing Address:					
	City, State, and Zip Code:					
	Home Telephone:		**Business Telephone:**		**Day Telephone:**	
	Work Email:					
	Personal Email:					
2.	**Attorney Information (if any):**					
	Attorney Name:					
	Street Address:					
	City:					
	State, Zip Code:					
	Telephone Number:		**Email:**			
3.	**Agency with whom who you are filing an appeal:**					
	Agency:					
	Street Address:					
	City:					
	State, Zip Code:					
	Telephone Number:		**Agency's Complaint Number:**			
4.	**Agency personnel with whom who you are filing an appeal:**					
A.	**Person One:**					
B.	**Person Two:**					
C.	**Person Three:**					
5.	**Has a final decision been made by your agency about this matter?**					
		Yes ☐ **No** ☐				
	If "**Yes**", please indicate the date you received the decision. Remember to attach a copy.	**Date Decision Received:**				
6.	**Describe the relief that you are seeking:**					

7.	**Have you filed a grievance about this matter?**			
	Yes ☐ **No** ☐ If "**Yes**", please provide a copy of grievance Form A and all associated documents and indicate the status of your grievance)			
8.	**Have you filed a complaint with the EEOC about this matter?**			
	Yes ☐ **No** ☐ If "**Yes**", please provide your case number:			
9.	**Have you filed a complaint with another agency about this matter?**			
	Yes ☐ **No** ☐ If "**Yes**", complete ***a*** through ***c*** below			
	a.	**Agency**:	**Contact Person:**	
	b.	**Address**:		
		City, State, and Zip Code:		
	c.	**Telephone Number:**	**Date Filed:**	
10.	**Have you filed a lawsuit about this matter?**			
	Yes ☐ **No** ☐ If "**Yes**", complete ***a*** and ***b*** below.			
	a.	**Name of Court**:		
	b.	**Case Docket Number**:	**Date Filed:**	

I affirm that the above information is true to the best of my knowledge, information and belief.

By submitting this form, I understand that an investigation will commence if the appeal is accepted and the agency that the appeal is filed against will be notified. I agree to cooperate with the investigation. I understand that the Office of Equity, Diversity, & Inclusion will request the agency which this appeal is filed against to release any and all personnel records, including but not limited to, medical records, deemed necessary to complete this investigation. Documents will only be shared with respect to the investigation and the performance of these duties.

This NOTICE OF APPEAL - COMPLAINANT - must be filed within 15 calendar days of the date of your agency's final decision upon which this appeal is based. The date the appeal is filed is the date on which it is postmarked, hand delivered, submitted, or faxed to the DHRM address above.

Signature: _____ Date: _____

FILING WITH THIS OFFICE DOES NOT PRECLUDE YOU FROM FILING WITH THE U.S. FEDERAL EQUAL EMPLOYMENT OPPORTUNITY COMMISSION OR OTHER FEDERAL AGENCIES.